CRIME VICTIMS REPARATIONS

MENTAL HEALTH TREATMENT PLAN – INITIAL FORM

THIS FORM IS TO BE COMPLETED BY THERAPIST WITHIN THE FIRST 4 WEEKS OF TREATMENT

CVR NUMBER:_____

VICTIM NAME:_____

CLAIMANT NAME:_____

ADDRESS:_____

VICTIM SSN:_____

DATE OF CRIME:_____

CLAIMANT INSTRUCTIONS:
Give this form to the therapist and ask that it be completed and returned to your Claims Investigator (CI). **You must also complete a CVR claim form for Medical, Mental Health and Funeral Expenses**.

PROVIDER INSTRUCTIONS:
Complete BOTH PAGES of this form and return along with itemized bills, to the CVR Claims Investigator in the sheriff's office.

Please Note: The LA CVR Board requires itemized bills (no insurance claim forms). The Board does not act as guarantor for any services provided.

DESCRIBE CLINICAL SYMPTOMS/DIAGNOSIS RELATED TO CRIME:_____
_____
_____

LIST PRIOR DIAGNOSES/TREATMENT:_____
_____
_____

DSM-IV-R DIAGNOSES: AXIS I_____ AXIS II_____ AXIS III_____ AXIS IV_____
AXIS V (Current GAF)_____

DATE TREATMENT BEGAN:____/____/____ ESTIMATED RESOLUTION DATE:____/_____/____

NOTE*: *A MORE DETAILED TREATMENT UPDATE FORM IS REQUIRED AFTER FIRST 6 MONTHS

IF INSURANCE IS AVAILABLE IT MUST BE FILED FIRST

INSURANCE NAME:_____

ADDRESS_____

CITY_____ ST_____ ZIP_____

POLICY NO_____ PHONE (_____)_____

CERTIFICATION: ***Have you received any federal funds to provide services (i.e., VOCA, VAWA grants)?*** ( ) Yes ( ) No

SIGNATURE OF LICENSED PROVIDER	TERMINAL DEGREE	LOUISIANA LICENSE NO.
PRINTED NAME	TELEPHONE NO.	DATE
NAME OF MENTAL HEALTH CLINIC OR HOSPITAL	FEDERAL EMPLOYER IDENTIFICATION #	
ADDRESS	CITY	STATE ZIP

PLEASE COMPLETE PAGE 2 ALSO

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Patient Name_____ **Page 2**

1) List targeted problem areas for this client that are related to their victimization.
2) For each problem area, list specific (i.e., quantifiable) goals of treatment.
3) Specifically describe how treatment goals will be accomplished via treatment interventions.
4) For each problem area, list an estimated resolution date**. (PLEASE NOTE THAT A MORE DETAILED TREATMENT UPDATE FORM WILL BE REQUIRED AFTER 6 MONTHS (calendar days).**

Problem Areas	Treatment Goals	Interventions	Est. Resolution Date